Standard Option dental benefits *(continued)*	Standard Option Only		
Covered service	**We pay**		**You pay**
Radiographs	**To age 13**	**Age 13 and over**	
Intraoral complete series	$36	$22	
Intraoral periapical first film	$7	$5	
Intraoral periapical each additional film	$4	$3	
Intraoral occlusal film	$12	$7	
Extraoral first film	$16	$10	
Extraoral each additional film	$6	$4	
Bitewing – single film	$9	$6	
Bitewings – two films	$14	$9	
Bitewings – four films	$19	$12	
Bitewings – vertical	$12	$7	
Posterior-anterior or lateral skull and facial bone survey film	$45	$28	
Panoramic film	$36	$23	
Tests and laboratory exams			
Pulp vitality tests	$11	$7	
Palliative treatment			
Palliative (emergency) treatment of dental pain – minor procedure	$24	$15	
Sedative filling	$24	$15	
Preventive			
Prophylaxis – adult*	---	$16	
Prophylaxis – child*	$22	$14	
Topical application of fluoride (including prophylaxis) – child*	$35	$22	
Topical application of fluoride (prophylaxis not included) – child	$13	$8	
Topical application of fluoride (prophylaxis not included) – adult	---	$8	
Topical application of fluoride (including prophylaxis) – adult*	---	$24	
**Limited to two per person per calendar year*			

All charges in excess of the scheduled amounts listed to the left

Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).

Dental benefits – continued on next page

Standard Option dental benefits *(continued)*	Standard Option Only		
Covered service	**We pay**		**You pay**
Space maintenance (passive appliances)	**To age 13**	**Age 13 and over**	
Space maintainer – fixed – unilateral	$94	$59	
Space maintainer – fixed – bilateral	$139	$87	
Space maintainer – removable – unilateral	$94	$59	All charges in excess of the scheduled amounts listed to the left
Space maintainer – removable – bilateral	$139	$87	
Recementation of space maintainer	$22	$14	
Amalgam restorations (including polishing)			*Note:* For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Amalgam – one surface, primary or permanent	$25	$16	
Amalgam – two surfaces, primary or permanent	$37	$23	
Amalgam – three surfaces, primary or permanent	$50	$31	
Amalgam – four or more surfaces, primary or permanent	$56	$35	
Filled or unfilled resin restorations			
Resin – one surface, anterior	$25	$16	
Resin – two surfaces, anterior	$37	$23	
Resin – three surfaces, anterior	$50	$31	
Resin – four or more surfaces or involving incisal angle (anterior)	$56	$35	
Resin-based composite – one surface, posterior	$25	$16	
Resin-based composite – two surfaces, posterior	$37	$23	
Resin-based composite – three surfaces, posterior	$50	$31	
Resin-based composite – four or more surfaces, posterior	$50	$31	
Inlay restorations			
Inlay – metallic – one surface	$25	$16	
Inlay – metallic – two surfaces	$37	$23	
Inlay – metallic – three or more surfaces	$50	$31	
Inlay – porcelain/ceramic – one surface	$25	$16	
Inlay – porcelain/ceramic – two surfaces	$37	$23	
Inlay – porcelain/ceramic – three or more surfaces	$50	$31	

Dental benefits – continued on next page

Standard Option dental benefits *(continued)*	Standard Option Only		
Covered service	**We pay**		**You pay**
Inlay restorations – continued	**To age 13**	**Age 13 and over**	
Inlay – composite/resin – one surface	$25	$16	
Inlay – composite/resin – two surfaces	$37	$23	
Inlay – composite/resin – three or more surfaces	$50	$31	All charges in excess of the scheduled amounts listed to the left *Note:* For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Other restorative services			
Pin retention – per tooth, in addition to restoration	$13	$8	
Extractions – includes local anesthesia and routine post-operative care			
Extraction, erupted tooth or exposed root	$30	$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27	
Surgical removal of residual tooth roots (cutting procedure)	$71	$45	
General anesthesia in connection with covered extractions	$43	$27	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Dental benefits – continued on next page

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $20 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, please refer to the Preferred provider directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
Covered service	**We pay**	**You pay**
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Radiographs Intraoral – complete series including bitewings *(limited to 1 complete series every 3 years)* Bitewing – single film* Bitewings – two films* Bitewings – four films* *Benefits are limited to a combined total of 4 films per person per calendar year		
Preventive Prophylaxis – adult *(up to 2 per calendar year)* Prophylaxis – child *(up to 2 per calendar year)** Topical application of fluoride (including prophylaxis) – child *(up to 2 per calendar year)** Topical application of fluoride (prophylaxis not included) – child *(up to 2 per calendar year)* Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)* *Benefits are limited to a combined total of 2 visits per person per calendar year		
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(i) Services, drugs, and supplies provided overseas

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this section, the same definitions, limitations, and exclusions also apply.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For professional care you receive overseas, we provide benefits at Preferred benefit levels using an Overseas Fee Schedule as our Plan allowance. **Under Standard Option,** you must pay any difference between our payment and the amount billed, in addition to any applicable deductible, coinsurance, and/or copayment amounts. You must also pay any charges for noncovered services.

Under Basic Option, you pay any difference between our payment and the amount billed, as well as the applicable copayment or coinsurance. You must also pay any charges for noncovered services. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States and Puerto Rico.**

For facility care you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 62-64.

For dental care you receive overseas, we provide benefits as described in Section 5(h). **Under Standard Option,** you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option,** you must pay the $20 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. The Worldwide Assistance Center can help you locate a hospital in our network near where you are staying. You may also view a list of our network hospitals on our Web site, www.fepblue.org. Although we do not have a network of professionals overseas, the Worldwide Assistance Center can also help you locate a physician. You will have to file a claim to us for reimbursement for professional services.

If you are overseas and need assistance locating providers, contact the Worldwide Assistance Center (provided by World Access Service Corporation); by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the Virgin Islands should call 1-800-699-4337. World Access Service Corporation also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States and Puerto Rico, send a completed Overseas Claim Form and itemized bills to: FEP Overseas Claims Section, CareFirst Blue Cross Blue Shield, P.O. Box 96242, Washington, DC 20090-6242. We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to this address or call us at 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. You may also obtain Overseas Claim Forms from this address, from our Web site (www.fepblue.org), or from your Local Plan.

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States and Puerto Rico, send a completed FEP Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

Please note that under both **Standard and Basic Options**, you may fill your prescriptions through a Preferred internet pharmacy only if the prescribing physician is licensed in the United States or Puerto Rico.

Under Standard Option, you may order your prescription drugs from the Mail Service Prescription Drug Program only if:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories) and
- The prescribing physician is licensed in the United States or Puerto Rico.

Please see page 84 for more information about using this program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Section 5(j) Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim with us for these services.

Discount Drug Program

The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual dysfunction: Caverject injection, Edex injection, Muse suppository, and Viagra tablet;

For weight loss: Meridia capsule and Xenical capsule;

For hair removal: Vaniqa cream;

For hair growth: Propecia; and

For pigmenting/depigmenting: Eldoquin, Solaquin, and Benoquin.

Drugs may be added to this list as they are approved by the Food and Drug Administration (FDA).

To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy (same as you do for drugs covered by the regular drug benefit). The pharmacist will process the prescription and ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Vision Care Program

Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using EyeMed Vision Care providers. Members have access to over 18,000 providers at over 10,000 locations, including LensCrafters®, independent optometrists, ophthalmologists, and opticians. For a complete description of the program or to find a provider near you, visit our Web site at www.fepblue.org or call EyeMed at 1-800-551-3337 from 8:00 a.m. to 11:00 p.m. eastern time, Monday through Saturday, and from 11:00 a.m. to 8:00 p.m. on Sunday.

Members can save on replacement contact lenses by visiting www.eyemedcontacts.com or calling 1-800-508-1399; however, a $2.95 administration fee applies to phone orders. Members can also save 15% off the retail price or 5% off promotional pricing on LASIK or PRK vision correction procedures. Simply call 1-877-552-7376 for the nearest laser facility and to receive authorization for the discount.

There are no enrollment fees or claim forms to be filed in this program. All charges for eye exams and eyewear are handled directly between you and the EyeMed provider.

Complementary Health Care

Service Benefit Plan members have the option of participating in an innovative program through American WholeHealth Networks, Inc. (AWHN). A $23 yearly membership fee provides access to a national network of wellness practitioners at discounted rates of up to 30% and nutritional supplements at discounts of up to 25%. In addition, members can save up to 50% at participating fitness clubs and spas. The broad range of program services includes Chiropractic, Acupuncture, Massage/Bodywork, Fitness Programs (including Yoga, Tai Chi/Qigong, Personal Trainers, and Pilates Instructors), Holistic Physicians, Diet and Supplement Advisors, and Mind/Body and Relaxation Techniques. Members also have access to AWHN's award-winning online member education tool WholeHealthMD. Members call providers directly to schedule appointments. No physician referral is required and there are no claim forms. All charges are handled directly between you and the AWHN providers.

For more information or to purchase a membership, visit our Web site at www.fepblue.org or call 1-877-258-7283 from 8:00 a.m. to 8:00 p.m. eastern time, Monday through Friday. The discount provider network is available to members nationwide, unless restricted by state law or regulation.

Federal DentalBlue

Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. To apply for Federal DentalBlue, you must be:

1. Enrolled in Standard Option and reside in one of the following Plan areas: Alabama, Oklahoma, or Washington State (only counties served by Regence BlueShield); or
2. Enrolled in Basic Option and reside in Alabama or Oklahoma.

To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your Local Plan.

Many other Blue Cross and Blue Shield Plans offer dental insurance to Service Benefit Plan members for an additional premium. For more information, contact your Local Plan about the availability of a non-FEHB dental program in your area.

Medicare Advantage Plan Enrollment

Some local Blue Cross and Blue Shield Plans offer Medicare recipients the opportunity to enroll in a Medicare Advantage plan without payment of an FEHB premium. Contact your local Blue Cross and Blue Shield Plan to find out if a Medicare Advantage plan is available in your area and the cost, if any, of that enrollment.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prosthesis to treat erectile dysfunction resulting from prostatectomy to treat prostate cancer);
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you would not be charged for if you had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service;
- Amounts charged that neither you nor we are legally obligated to pay, such as amounts over the Medicare limiting charge or equivalent Medicare amount as described in Section 4 under *Your costs for covered services*, or State premium taxes, however applied;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption;
- Services or supplies (except for medically necessary prescription drugs) that you receive from a noncovered facility, such as an extended care facility or nursing home, except as specifically described in Sections 5(a) and 5(c);
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 10;
- Services, drugs, or supplies you receive for cosmetic purposes;
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures and those nutritional counseling services specifically listed on pages 27, 44, and 60;
- Services you receive from a provider that are outside the scope of the provider's licensure or certification;
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(h), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*;
- Orthodontic care for temporomandibular joint (TMJ) syndrome;
- Services of standby physicians;
- Self-care or self-help training;
- Custodial care;
- Personal comfort items such as beauty and barber services, radio, television, or telephone;
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs;
- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c) and screenings specifically listed on page 28;
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay;
- Topical Hyperbaric Oxygen Therapy (THBO); or
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form.

When you must file a claim – such as when another group health plan is primary – submit it on the HCFA-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) form from any primary payer [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, home nursing care, and physical, occupational, and speech therapy, require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, or through the Mail Service Prescription Drug Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See below for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, and the Mail Service Prescription Drug Program.)

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our Web site, www.fepblue.org, click on "Pharmacy Programs," and follow the FEP Retail Pharmacy Providers link to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Prescription drug claims *(continued)*

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 14).

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail or internet pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail or internet pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

1) Complete the initial mail order form;

2) Enclose your prescription and copayment;

3) Mail your order to Caremark, P.O. Box 52056, Phoenix, AZ 85072; and

4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-866-409-8525). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care), apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 95 and 96 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification or prior approval:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 1, 1900 E Street, NW, Washington, DC 20415-3610.

The disputed claims process *(continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We have not responded yet to your initial claim or request for precertification/prior approval, then call us at the customer service number on the back of your Service Benefit Plan ID card and we will expedite our review; or

(b) We denied your initial claim or request for precertification/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 1 at 1-202-606-0727 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payer's benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payer.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services,* for more information about how we pay claims.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983, or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 106.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you do not have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 13 for exception).

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-admission copayments;
  - Inpatient Non-member hospital coinsurance; and
  - Non-Preferred inpatient per-day copayments for mental conditions/substance abuse care.
- Under **Basic Option**, we will waive our:
  - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
  - Copayments for office visits to Preferred physicians and other health care professionals;
  - Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
  - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You will be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 11 for the exceptions to this requirement.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart

A. When you – or your covered spouse – are age 65 or over and have Medicare and you. . .	**The primary payer for the individual with Medicare is. . .**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and… • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member…		
1) Have Medicare solely based on end stage renal disease (ESRD) and… • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and… • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you…		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Workers' Compensation is primary for claims related to your condition under Workers' Compensation

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under these programs.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we provide benefits for that injury, you must agree to the following provisions:

- All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.
- We will not reduce our share of any recovery unless we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees. This is our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
- If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover.

You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

The following are examples of circumstances in which we may subrogate or assert a right of recovery:

- When you or your dependent are injured on premises owned by a third party; or
- When you or your dependent are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - Personal injury protection benefits
  - Uninsured and underinsured motorist coverage (does not include no-fault automobile insurance)
  - Workers' compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

Section 10. Definitions of terms we use in this brochure

Accidental injury

An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. ***Note:*** Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.

Admission

The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.

Assignment

An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Carrier

The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See pages 15-16.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

Cosmetic surgery

Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as Long Term Care. The Carrier, its medical staff, and/or an independent medical review determines which services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 15.

Durable medical equipment

Equipment and supplies that:

1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished. ***Note:*** Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

   Reliable evidence shall mean only:

   - published reports and articles in the authoritative medical and scientific literature;
   - the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
   - the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Each Local Plan has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

For more detailed information, contact your Local Plan at the customer service telephone number located on the back of your Service Benefit Plan ID card.

Group health coverage

Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Intensive outpatient care

A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Lifetime maximum

The maximum amount the Plan will pay on your behalf for covered services you receive while you are enrolled in your option. Benefit amounts accrued are accumulated in a permanent record regardless of the number of enrollment changes. Please see page 79.

Local Plan

A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical necessity

We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;
3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Mental conditions/substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Partial hospitalization

An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base our payment, and your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers** – Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail and internet pharmacies that contract with Caremark) have agreed to accept as payment in full, when we pay primary benefits.

  Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 90 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers** – Our allowance (which we may refer to as the "PA" or "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.

- **Non-participating providers** – We have no agreements with these providers. We determine our allowance as follows:

  - For inpatient services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is based on a per diem amount for your type of admission developed from the average amount paid "for our members" nationally to contracting and non-contracting facilities. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;

  - For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is the average amount for outpatient surgical services that we pay nationally to contracting and non-contracting facilities. For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury, our allowance is the billed amount (minus any amounts for noncovered services);

  - For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the 2006 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");

  - For prescription drugs furnished by retail and internet pharmacies that do not contract with Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth in the most current version of First DataBank's National Drug Data File; and

  - For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with World Access, Inc., our allowance is an Overseas Fee Schedule that is based on amounts comparable to what Participating providers in the Washington, DC, area have agreed to accept.

Non-participating providers are under no obligation to accept our allowance as payment in full. If you use Non-participating providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances – see page 114). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment amounts.

Note: For **certain** claims for services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the provider's billed amount is greater than $5,000, your responsibility will be limited to $5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts), as long as the services are covered.

- When you receive care from a Non-participating radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, or emergency room physician in a Preferred hospital;
- When you receive care in a Member or Non-member hospital from a Non-participating radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, or emergency room physician as part of the emergency services you receive for a medical emergency or accidental injury (see page 68);
- For surgery provided by a Non-participating provider in a Preferred, Member, or Non-member hospital as part of the emergency services you receive for a medical emergency or accidental injury; and
- Ambulance services billed by a Non-participating professional provider and associated with a medical emergency or accidental injury.

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 17, 95, and 96.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail and internet pharmacies, between pharmacies and Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed;
2. The Retail Pharmacy Program (for prescription drugs and supplies purchased through Preferred retail and internet pharmacies) or the Mail Service Prescription Drug Program; or
3. The Blue Cross and Blue Shield Association Clinical Trials Information Unit for certain organ/tissue transplants we cover only in clinical trials. See Section 5(b).

For more information, see the benefit descriptions in Section 5 and *How to get approval for . . . Other services* on pages 13-14. See Section 5(e) for special authorization requirements for mental health and substance abuse benefits.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Transplant period

A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Us/We/Our

"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. FEHB facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next Open Season for enrollment begins.

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **Your medical and claims records are confidential**

We will keep your medical and claims information confidential. Please note that as part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health benefits coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you do not have self and family health benefits coverage. ***Note:*** The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is $5,000. ***Note:*** The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for an HCFSA up to the maximum of $5,000 each ($10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is $250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return and who is mentally or physically incapable of self care.
- The maximum annual amount that can be allotted for the DCFSA is $5,000. The minimum annual amount is $250. ***Note:*** The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is $5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled for 2005, you must make a new election to continue participating in 2006. Enrollment is easy!

- Online: visit **www.FSAFEDS.com** and click on Enroll.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

- **Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you are not enrolled in FEHB – you can choose to participate in either, or both, of the FSAFEDS accounts. *However, if you elect an FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) instead.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called "when actually employed" [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s). This is known as the "Use-it-or-Lose-it" rule. FSAFEDS has adopted the "grace period" permitted by the IRS. You now have an additional 2½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15. For example, if you enrolled in FSAFEDS for the 2006 Plan Year, you will have until May 31, 2007, to submit claims for eligible expenses. [And, if your 2006 balance is not sufficient to reimburse you in full for eligible expenses incurred from January 1, 2007 through March 15, 2007, the unpaid balance will be paid out of your 2007 account if you re-enroll during Open season. If you do not re-enroll, you cannot be reimbursed in full for those expenses.]

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on pages 123 and 124 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that are NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the Standard Option of this Plan, typical out-of-pocket expenses include: copayments for hospital stays and office visits, deductible and coinsurance amounts for certain diagnostic tests, and coinsurance amounts for retail pharmacy prescription drug purchases. Other out-of-pocket expenses include amounts that you pay for noncovered services such as routine eye and hearing exams, hearing aids, and certain dental procedures.

Under the Basic Option of this Plan, typical out-of-pocket expenses include: copayments for hospital stays, office visits, and certain retail pharmacy prescription drug purchases. Other out-of-pocket expenses include amounts that you pay for noncovered services and supplies such as care received from Non-preferred providers, certain dental procedures, and physical, speech, and occupational therapies in excess of visit limits.

The IRS governs expenses reimbursable by an HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help with preparing your Federal Income Tax return, there are two important differences to note. *Note:* **While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at www.irs.gov/pub/irs-pdf/p502.pdf. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses ***before*** your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	**With FSA**	**Without FSA**
If your taxable income is:	$50,000	$50,000
And you deposit this amount into an FSA:	$2,000	-$0-
Your taxable income is now:	$48,000	$50,000
Subtract Federal & Social Security taxes:	$13,807	$14,383
If you spend after-tax dollars for expenses:	-$0-	$2,000
Your real spendable income is:	$34,193	$33,617
Your tax savings:	**$576**	**-$0-**

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received $2,000 in services for $1,424 – a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you have elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding $3,750 (7.5% of $50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. You must re-enroll every Open Season to remain in the paperless reimbursement program. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal Tax Credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you do not spend your entire account balance during your period of coverage for the Plan Year plus 2 ½ month grace period, resulting in the forfeiture of funds remaining in your account (the IRS "Use-it-or-Lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program** (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you are in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You do not have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2006

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $250 per person ($500 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Benefits	You Pay	Page(s)
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: 10%* of our allowance; $15 per office visit Non-PPO: 25%* of our allowance	26-28
Services provided by a hospital:		
• Inpatient	PPO: $100 per admission Non-PPO: $300 per admission	59-61
• Outpatient	PPO: 10%* of our allowance (no deductible for surgery) Non-PPO: 25%* of our allowance (no deductible for surgery)	62-64
Emergency benefits:		
• Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter	69-70
• Medical emergency	Regular benefits for physician and hospital care*; 10% of our allowance for ambulance transport services (no deductible)	71
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $15 office visit copay; $100 per inpatient admission Out-of-Network (Non-PPO): Benefits are limited	74-79
Prescription drugs	Retail Pharmacy Program: • PPO: 25% of our allowance; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program: • $10 generic/$35 brand-name per prescription; up to a 90-day supply	82-87
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	49, 89-93
Special features: Flexible benefits option; online customer and claims service; 24-hour nurse line; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; and Healthy Families Program		88
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $4,000 (PPO) or $6,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	18-19

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2006

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 11. There is no deductible for Basic Option.

Benefits	You Pay	Page(s)
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $20 per office visit for primary care physicians and other health care professionals; $30 per office visit for specialists Non-PPO: You pay all charges	26-28
Services provided by a hospital:		
• Inpatient	PPO: $100 per day up to $500 per admission Non-PPO: You pay all charges	59-61
• Outpatient	PPO: $40 per day per facility Non-PPO: You pay all charges	62-64
Emergency benefits:		
• Accidental injury	PPO: $50 copayment for emergency room care; $30 copayment for urgent care Non-PPO: $50 copayment for emergency room care	69-70
• Medical emergency	Same as for accidental injury	71
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $20 office visit copayment (prior approval required); $100 per day up to $500 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	74-79
Prescription drugs	Retail Pharmacy Program: • PPO: $10 generic/$30 formulary brand-name per prescription/50% coinsurance ($35 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges	82-87
Dental care	PPO: $20 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $20 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	49, 89-90, 91
Special features: Flexible benefits option; online customer and claims service; 24-hour nurse line; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; and Healthy Families Program		88
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 (PPO) per contract per year; some costs do not count toward this protection	18-19

2006 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Enrollment Code	*Non-Postal Premium* Biweekly Government Share	*Non-Postal Premium* Biweekly Your Share	*Non-Postal Premium* Monthly Government Share	*Non-Postal Premium* Monthly Your Share	*Postal Premium* Biweekly USPS Share	*Postal Premium* Biweekly Your Share
Standard Option Self Only	104	$139.18	$58.07	$301.56	$125.82	$164.31	$32.94
Standard Option Self and Family	105	$316.08	$135.59	$684.84	$293.78	$373.15	$78.52
Basic Option Self Only	111	$113.99	$37.99	$246.97	$82.32	$134.88	$17.10
Basic Option Self and Family	112	$266.99	$88.99	$578.47	$192.82	$315.93	$40.05

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Fee-For-Service Carrier

Blue Cross and Blue Shield Association
CONTRACT NO. CS 1039

Effective January 1, 2006

(a) Biweekly net-to-carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Regular Rates

Standard Option		Basic Option	
Self only	$189.66	Self Only	$146.13
Self and Family	$434.30	Self and Family	$342.29

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

Item	Amount
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2006
(ii) Taxes	Actual (except that premium taxes as defined are not allowable).
(iii) Service Charge	0.72% of estimated incurred claims and allowable administrative expenses or $140 million

(c) The Contractual Expense Limitation for 2006 is $856 million and will equal the base for calculating the 2007 Contractual Expense Limitation. The Contractual

Expense Limitation for 2006 includes all administrative costs for managed care associated with precertification; prior approval; Preferred Provider Organization (PPO) directories; PPO Provider Relations, Reimbursement and Networks; and ancillary network management. An additional amount equal to actual 2005 Mental Health and Substance Abuse and HIPAA privacy and security costs deemed regular recurring costs and increased by 6 percent will be added to the 2006 base amount, and will be included in the calculation of the 2007 contract limit.

(d) The Carrier may charge costs to comply with the Health Insurance Portability and Accountability Act's administrative simplification, privacy, and security provisions ("HIPAA compliance costs") to the contract. These costs are subject to audit and must be actual, allowable, allocable, and reasonable under the FAR and FEHBAR. These costs must first be charged to the difference, if any, between the Contractual Expense Limitation for all other administrative expenses, as shown in Subsection (c) of Appendix B of this contract, and the Carrier's regular non-HIPPA administrative costs incurred and charged for the contract period. If the HIPAA compliance costs, when combined with the non-HIPAA administrative costs, exceed the Contractual Expense Limitation, the Carrier may charge up to $13,100,000 of HIPAA compliance costs (the "HIPAA Expense Limitation") outside of the Contractual Expense Limitation, between January 1, 2006 and December 31, 2006. The same cost may not be charged under both the HIPAA Expense Limitation and the Contractual Expense Limitation. This separate HIPAA Expense Limitation, including any balance remaining on December 31, 2006, will not be available after December 31, 2006.

APPENDIX C

FEHB Supplemental Literature Guidelines
(RV JAN 2000)

This is the primary guide a Carrier should use to assess whether the Carrier's supplemental marketing literature, including website material, complies with FEHBAR 1603.70, Misleading, Deceptive or Unfair Advertising. (Use the NAIC Guidelines for additional guidance when needed.)

a) GENERAL

1. Section 1.13 of the FEHB contract requires that the Carrier may not distribute or display marketing materials or other supplemental literature (including provider directories) in a Federal facility or arrange for the distribution of such documents by Federal agencies unless the documents have been prepared in accordance with FEHBAR 1652.203-70, and the Carrier has certified to OPM that is the case.

2. Review supplemental marketing material for compliance each year, whether or not it changed from the past year.

3. Word the literature simply and concisely to get a readily understandable, attractive marketing piece.

4. Include sufficient detail to ensure accuracy.

5. Under the FEHBP, the FEHB brochure is based on text approved by OPM and is a complete statement of benefits, limitations, and exclusions. Include the following statement (website material should include the statement as a preface) in all supplemental literature which in any way discusses Plan benefits:

"This is a summary [or brief description] of the features of the [insert Plan's name]. Before making a final decision, please read the Plan's Federal brochure ([insert brochure number]). All benefits are subject to the definitions, limitations, and exclusions set forth in the Federal brochure."

6. You may include non-FEHBP benefits, i.e., benefits which are not FEHB benefits and are not guaranteed under the Federal contract with the following disclaimer:

"These benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all enrollees and family members who become members of [insert Plan's name]."

7. Supplemental literature must be clearly distinguishable from the Federal brochure.

8. Do not use the FEHB logo in your supplemental literature.

9. Do not use material which conflicts with the Federal brochure. If your material conflicts, you must change the material or not distribute it.

b) RATE PRESENTATIONS

Under the FEHBP there are only two categories of enrollment, Self Only and Self and Family. For most enrollments, the premium for each enrollee's enrollment is shared between the enrollee and the Government. The Government contribution is based on the formula provided in the FEHB law. Deductions for most enrollees' share, along with the Government's contribution, are made in accordance with the schedule on which the employee or annuitant's (retiree) salary

or annuitant check is issued by the enrollee's agency or retiree's retirement system. Most employees are paid biweekly. Annuitants are issued monthly checks.

Employees and annuitants do not have separate categories of enrollment. They pay the same rates, whether on a biweekly, semimonthly, or monthly basis, and receive the same benefits when they are in the same FEHB Plan, except that active Postal employees pay a lesser share, as their cost sharing formula with the Postal Service calls for a greater Government contribution.

The enrollee's share for each FEHB Plan for each type of enrollment (Self Only, Self and Family) is listed in the *FEHB Guide*. This Guide is prepared each Open Season and is distributed directly to agencies by OPM; they in turn distribute the Guide to employees. Biweekly and monthly rates are also shown on an insert you prepare for your brochure. Separate guides are prepared for special groups of enrollees, including those for which the Government makes no premium contribution, such as former spouses and employees and dependents with temporarily continued coverage.

In making your rate presentations:

1. List your FEHB rates in each piece of supplemental material which lists benefits. Do not list the rates of any competitor Plan.

2. Immediately above the rates include the following statement:

"These rates do not apply to all enrollees. If you are in a special enrollment category, please refer to your special FEHB Guide or contact the agency which maintains your health benefits enrollment."

3. If you wish to list Postal rates in addition to non-Postal rates, Postal and non-Postal rates should be clearly identified and listed separately. (Please note there are no monthly Postal rates; upon retirement, Postal employees receive the non-postal contribution.)

c) BENEFIT PRESENTATIONS

Please note the following:

1. Do not compare your benefits or operations with that of any other Plan.
2. Accurately describe your FEHB benefits offering.
3. Avoid incomplete or overstated benefit descriptions, or those which conflict with the Federal brochure.
4. Show applicable coverage limitations, such as day or dollar limitations, coinsurance or deductibles.
5. Do not list exclusions and limitations not listed in the Federal brochure.
6. Do not include general references not in the brochure.
7. Do not reference coverage for which a Federal employee or retiree would have to drop FEHB coverage. Exception: 5 CFR 890.301 provides that an annuitant or former spouse, as defined in 5 U.S.C. 8901(10), who cancels FEHBP enrollment for the purpose of enrolling in a prepaid health Plan under sections 1833 or 1876 of the Social Security Act may register to re-enroll. Therefore, if your's is such a prepaid Plan contracting with Medicare you must describe your Medicare supplemental program for Medicare-covered retirees.

d) ENROLLMENT INSTRUCTIONS

Enrollment under the FEHBP is governed solely by the Federal Employees Health Benefits law and applicable regulations. The various Federal agencies have responsibility for administering the law and regulations during the annual open enrollment period (Open Season) and at all other times during the year. Agency personnel offices perform the basic health

benefits functions, such as instructing employees about the conduct of the Open Season and other health benefits matters, answering employee questions, and processing elections and changes of enrollment, including determinations of eligibility and assignment of effective dates of coverage. Agency payroll offices make the necessary salary deductions.

The Federal instrument for electing to enroll in a Plan or changing an existing enrollment in a Plan from Self Only to Self and Family (or the reverse) is the Standard Form (SF) 2809, or alternative electronic or telephonic method approved by OPM. Carriers must be able to accept electronic file transfers. The effective date for Open Season enrollments is the first day of the first pay period which begins on or after January 1 for employees; the effective date generally is January 1 for annuitants. The specific effective date for an individual will be assigned by the individual's personnel office.

Covered dependents are as defined in the FEHB regulations. Basically, dependents are immediate family members, including spouse and unmarried children under age 22. When Self and Family coverage is established for an individual, all dependents as defined under the regulations are automatically covered as of the effective date assigned by the personnel office, whether or not they are listed on the SF 2809, on other documents, or communicated by electronic or telephonic transmittal. Family members (e.g., newborns) who are added under an existing Self and Family enrollment are automatically covered from the date the individual becomes a family member, e.g., from birth. Personnel offices do not issue any notification when a new dependent is added under an existing Self and Family enrollment and the enrollee does not submit a new SF 2809 or other election instrument.

The agencies are the primary contact point for employees on health benefits enrollment matters. OPM's Office of Retirement Programs performs this function for annuitants (retirees). As highlighted below, Carriers may not impose their own enrollment requirements and procedures.

1. Do not give specific instructions on enrollment. Statements regarding election of coverage or change of enrollment procedures, requirements, or eligibility must be limited to referring individuals to their personnel office for the appropriate instructions; your plan's Self Only and Self and Family enrollment codes; and notice for retirees to contact their retirement system for instructions.

2. While the Carrier may ask enrollees for information (see Section f) and may follow-up with enrollees and, when necessary, the employing office, the Carrier will not require a member to complete plan specific enrollment or application forms. (You may ask the enrollee to complete "information" forms.) You may ask the enrollee to keep you advised of family member changes and you may verify the change, but failure to complete a form does not render an eligible dependent ineligible.

3. Personnel offices will not stock your Plan's forms. Do not indicate otherwise.

4. If supplemental literature is directed to potential members rather than just-enrolled members, do not include statements indicating otherwise.

5. Again, the Federal brochure, rather than any other plan document, is the member's complete statement of benefits. Do not indicate otherwise.

e) PROVIDER DIRECTORIES

Carriers must distribute a provider directory along with the Plan's Federal brochure. The directory must conform to the requirements listed below. You must either send a copy of it along with your Federal brochures (except that provider directories are not to be sent along with

the brochures you will be sending to OPM's distribution center for annuitants) or otherwise make them readily available to agencies and employees. Provider directories are to be sent to any annuitant who requests one. Agencies and their employees will be advised to expect your provider directory.

Please bear in mind that a Federal employee or annuitant choosing your Plan during the Open Season is doing so with the expectation that the Plan's provider directory is accurate and that providers shown will be available starting January 1.

1. Show the Plan's hospitals, individual physicians, and group practice medical facilities. State the addresses of the medical facilities and show the general location within the service area for individual doctors and hospitals.

2. In the directory, display prominently the following statement: "It is important to know when you enroll in this Plan, benefits are available as described in the Plan's Federal brochure, but the continued participation of any one doctor, hospital or other provider cannot be guaranteed."

3. Do not list enrollment or eligibility requirements on the provider directory.

f) INFORMATION FORMS

You may distribute forms to obtain information from enrollees about the enrollee and any dependents. For instance, to obtain the information regarding Medicare you will need for rate-setting purposes under the Federal Program, you may ask who is enrolled under Medicare Part A, Medicare Part B or Medicare Parts A and B. For another example, Carriers may ask that a primary care doctor be selected for a Point of Service product. If you wish to distribute an information form, you may find such forms are more readily returned if they are postage-paid. Do not indicate enrollment in the Plan is contingent upon completing and returning the form.

APPENDIX D
RULES FOR COORDINATION OF BENEFITS

Model Regulation Service--January 1996
National Association of Insurance Commissioners

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

D. Order of Benefit Determination

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the plan covering the person as a dependent; and

(b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan.

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) The parents are married;

(ii) The parents are not separated (whether or not they ever have been married); or

(iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(d) If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the noncustodial parent; and then

(iv) The plan of the spouse of the noncustodial parent.

(3) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection D(1).

Drafting Note: *This rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies.*

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Drafting Note: *The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) originally provided that coverage under a new group health plan caused the COBRA coverage to end. An amendment passed as part of P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989 (COBRA 89) allows the COBRA coverage to continue if the new group plan contains any preexisting condition limitation. In this instance two group plans will cover an individual, and the rule above will be used to determine which of them assumes the primary position. In addition, some states have continuation provisions comparable to the federal law.*

(5) Longer or Shorter Length of Coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

(b) The start of a new plan does not include:

(i) A change in the amount or scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

APPENDIX E

Small Business Subcontracting Plan (JAN 2002)

(a) This clause does not apply to small business concerns.

(b) *Definitions*. As used in this clause—

"Commercial item" means a product or service that satisfies the definition of commercial item in section 2.101 of the Federal Acquisition Regulation.

"Individual contract plan" means a subcontracting plan that covers the entire contract period, applies to a specific contract, and has goals that are based on the Carrier's planned subcontracting in support of the specific contract, except that indirect costs incurred for common or joint purposes may be allocated on a prorated basis to the contract.

"Subcontract" as used in this clause means any agreement (other than one involving an employer-employee relationship) entered into by the Carrier or its subcontractor calling for supplies or services required for performance of the contract or subcontract, except for agreements with providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

(c) The Carrier, upon request by the Contracting Officer, shall submit and negotiate a subcontracting plan, where applicable, that separately addresses subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business concerns, small disadvantaged business, and women-owned small business concerns. The subcontracting plan shall be included in and made a part of the resultant contract. The subcontracting plan must separately address subcontracting with small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns. The subcontracting plan shall be negotiated within the time specified by the Contracting Officer.

(d) The Carrier's subcontracting plan shall include the following:

(1) Goals, expressed in terms of percentages of total planned subcontracting dollars, for the use of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns as subcontractors. The Carrier shall include all subcontracts that contribute to contract performance, and may include a proportionate share of products and services that are normally allocated as indirect costs.

(2) A statement of—

(i) Total dollars planned to be subcontracted for the individual contract plan;

(ii) Total dollars planned to be subcontracted to small business concerns;

(iii) Total dollars planned to be subcontracted to veteran-owned small business concerns;

(iv) Total dollars planned to be subcontracted to service-disabled veteran-owned small business concerns;

(v) Total dollars planned to be subcontracted to HUBZone small business concerns;

(vi) Total dollars planned to be subcontracted to small disadvantaged business concerns; and

(vii) Total dollars planned to be subcontracted to women-owned small business concerns.

(3) A description of the principal types of supplies and services to be subcontracted, and an identification of the types planned for subcontracting to—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business concerns;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(4) A description of the method used to develop the subcontracting goals in paragraph (d)(1) of this clause.

(5) A description of the method used to identify potential sources for solicitation purposes (*e.g.*, existing company source lists, the Procurement Marketing and Assistance Network (PRO-Net) of the Small Business Administration (SBA), veterans service organizations, the National Minority Purchasing Council Vendor Information Service, the Research and Information Division of the Minority Business Development Agency in the Department of Commerce, or small, HUBZone, small disadvantaged, and women-owned small business trade associations). A Carrier may rely on the information contained in PRO-Net as an accurate representation of a concern's size and ownership characteristics for the purposes of maintaining a small, veteran-owned small, service-disabled veteran-owned small, HUBZone small, small disadvantaged, and women-owned small business source list. Use of PRO-Net as its source list does not relieve a Carrier of its responsibilities (*e.g.*, outreach, assistance, counseling, or publicizing subcontracting opportunities) in this clause.

(6) A statement as to whether or not the Carrier included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with—

(i) Small business concerns;

(ii) Veteran-owned small business concerns;

(iii) Service-disabled veteran-owned small business;

(iv) HUBZone small business concerns;

(v) Small disadvantaged business concerns; and

(vi) Women-owned small business concerns.

(7) The name of the individual employed by the Carrier who will administer the Carrier's subcontracting program, and a description of the duties of the individual.

(8) A description of the efforts the Carrier will make to assure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small

business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts.

(9) Assurances that the Carrier will include the clause of this contract [FAR 52.219-8] entitled "Utilization of Small Business Concerns" in all subcontracts that offer further subcontracting opportunities, and that the Carrier will require all subcontractors (except small business concerns) that receive subcontracts in excess of $500,000 to adopt a subcontracting plan that complies with the requirements of this clause.

(10) Assurances that the Carrier will—

(i) Cooperate in any studies or surveys as may be required;

(ii) Submit periodic reports so that the Government can determine the extent of compliance by the Carrier with the subcontracting plan;

(iii) Submit Standard Form (SF) 294, Subcontracting Report for Individual Contracts, and SF 295, Summary Subcontract Report, in accordance with the instructions on the forms, or as provided in agency regulations and paragraph (g) of this clause; and (iv) ensure that its subcontractors agree to submit Standard Forms 294 and 295.

(11) A description of the types of records the Carrier will maintain concerning procedures that have been adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of its efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and award subcontracts to them. The records shall include at least the following (on a company-wide basis, unless otherwise indicated):

(i) Source lists (*e.g.,* PRO-Net), guides, and other data that identify small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

(ii) Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.

(iii) Records on each subcontract solicitation resulting in an award of more than $100,000, indicating—

(A) Whether small business concerns were solicited and, if not, why not;

(B) Whether veteran-owned small business concerns were solicited and, if not, why not;

(C) Whether service-disabled veteran-owned small business concerns were solicited and, if not, why not;

(D) Whether HUBZone small business concerns were solicited and, if not, why not;

(E) Whether small disadvantaged business concerns were solicited and, if not, why not;

(F) Whether women-owned small business concerns were solicited and, if not, why not; and

(G) If applicable, the reason award was not made to a small business concern.

(iv) Records of any outreach efforts to contact—

(A) Trade associations;

(B) Business development organizations;

(C) Conferences and trade fairs to locate small, HUBZone small, small disadvantaged, and women-owned small business sources; and

(D) Veterans service organizations.

(v) Records of internal guidance and encouragement provided to buyers through—

(A) Workshops, seminars, training, etc.; and

(B) Monitoring performance to evaluate compliance with the program's requirements.

(vi) On a contract-by-contract basis, records to support award data submitted by the Carrier to the Government, including the name, address, and business size of each subcontractor.

(e) In order to effectively implement this plan to the extent consistent with efficient contract performance, the Carrier shall perform the following functions:

(1) Assist small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns by arranging solicitations, time for the preparation of bids, quantities, specifications, and delivery schedules so as to facilitate the participation by such concerns. Where the Carrier's lists of potential small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business subcontractors are excessively long, reasonable effort shall be made to give all such small business concerns an opportunity to compete over a period of time.

(2) Counsel and discuss subcontracting opportunities with representatives of small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business firms.

(3) Provide notice to subcontractors concerning penalties and remedies for misrepresentations of business status as small, veteran-owned small business, HUBZone small, small disadvantaged, or women-owned small business for the purpose of obtaining a subcontract that is to be included as part or all of a goal contained in the Carrier's subcontracting plan.

(f) The failure of the Carrier or subcontractor to comply in good faith with (1) the clause of this contract entitled "Utilization Of Small Business Concerns;" or (2) an approved plan required by this clause, shall be taken into consideration by the Contracting Officer in determining the Carrier's service charge, if any.

(g) The Carrier shall submit the following reports:

(1) *Standard Form 294, Subcontracting Report for Individual Contracts.* This report shall be submitted to the Contracting Officer semiannually and at contract completion. The report covers subcontract award data related to this contract.

(2) *Standard Form 295, Summary Subcontract Report.* This report encompasses all the Carrier's contracts under the Federal Employees Health Benefits Program. It must be submitted

annually. All reports submitted at the close of each fiscal year shall include a breakout, in the Carrier's format, of subcontract awards, in whole dollars, to small disadvantaged business concerns by North American Industry Classification System (NAICS) Industry Subsector.

(end of clause)

Appendix E

2006

SMALL BUSINESS SUBCONTRACTING PLAN

BLUE CROSS AND BLUE SHIELD ASSOCIATION

FEDERAL EMPLOYEE PROGRAM

BCBS PLAN SUBCONTRACTING PLAN
(FISCAL YEAR 2006)

Carrier:	Blue Cross and Blue Shield Association Federal Employee Program
Address:	1310 G. Street N. W. Washington, D. C. 20005
Total Amount of Contract:	$15,000,000,000 (Est.)

Period of Contract Performance (DAY, MO. & YR.)
1 January, 2006 through 31 December, 2006

Period of **this Small Business Subcontracting Plan** – (DAY, Mo. & YR.)
1 October, 2005 through 30 September 2006

1. Type of Plan

This is a small business subcontracting plan (SADBUS Plan) providing estimates of small business contracting activity by the Blue Cross and Blue Shield Federal Employee Program (FEP) participating Plan indicated above covering contracting activity for fiscal year 2006. This information is submitted in accordance with and as required by U.S. Government, Office Of Personnel Management (OPM) contract C.S. 1039, and other related rules and regulations.

Definition: **Target Firm(s)** – Throughout this Subcontracting Plan the term "Target Firm(s)" will be utilized to refer collectively to Small Business, Women Owned Small Business, Small Disadvantaged Owned Business, HUBZone Small Business, Veteran Owned Small Business and Service Disabled Veteran Owned Small Business. When a reference is intended to refer a specific grouping within the small business program, the name of that individual category(s) will be spelled out in its entirety.

2. Goals

State separate dollar and percentage goals for targeted firm(s) in the following format. (For a contract with options, provide a separate statement for the basic contract and individual statement for each option year.)

A. Total estimated dollar value and percent of planned subcontracting with **small business** (include small disadvantaged and women-owned small businesses): (% of "H")

$52,160,145.00 And 53%

B. Total estimated dollar value and percent of planned subcontracting with **small disadvantaged businesses**: (% of "H")

$4,956,626.00 and 5%

C. Total estimated dollar value and percent of planned subcontracting with **women-owned small businesses**: (% of "H")

$4,956,626.00 and 5%

D. Total estimated dollar value and percent of planned subcontracting with **Certified HUBZone Small Business Concerns**: (% of "H")

$3,965,301.00 and 4%

E. Total estimated dollar value and percent of planned subcontracting with **Veterans Owned Small Business**: (% of "H")

$4,956,626.00 and 5%

F. Total estimated dollar value and percent of planned subcontracting with **Service Disabled Veterans Owned Small Business**: (% of "H")

$2,973,975.00 and 3%

G. Total Estimated dollar value and percent of planned subcontracting with **large businesses** (all business concerns classified as "other `an small"): (% of "H")

$46,972,381.00 and 47%

H. Total estimated dollar value of all planned subcontracting i.e., the sum of A and G above: $99,132,526.00 (100 per cent).

I. The following table identifies the principal products and/or services to be subcontracted under this contract, and the types of targeted firm(s) supplying them: (check all that apply)

Subcontracted Product/Service	Other	SB	SDB	WOSB	HUB-Zone	VOSB	DVOSB
Subscriber information systems	X						
Software	X	X					
Computer equipment	X	X					
Claims processing	X	X			X		
Data entry		X	X	X	X		
Printing	X	X	X	X	X	X	X
Training	X	X					
Premium items		X	X	X	X	X	X
Audit services	X	X					
Graphic design services		X	X	X			
Meeting services	X						
Equipment rental	X	X					
Office furniture	X	X					
Office supplies	X	X	X	X	X	X	X
Building supplies	X	X	X	X	X	X	X
Building services		X	X	X	X	X	X
Temporary help		X	X	X	X		
Subscriber research	X	X	X	X			
Technical consulting services	X	X	X	X			

Provide a description of the method used to develop the subcontracting goals for targeted firm(s), i.e., explain the method and state the quantitative basis (in dollars) used to establish the percentage goals. Include any source lists used in the determination process.

The various BCBS Plans (45+ Plans) each determine their own individual goals and objectives by methods consistent with the local Plan environment as well as their own history and experience. In all instances, the projection of a goal for an upcoming year involves looking at actual performance for the past period, considering approved budgets and financial plans for the upcoming period and making an educated estimate as to whether the past year's data contains any anomalies, or is of such a routine nature that it can be used, with minor adjustments, to reasonably reflect what can be expected in the upcoming period.

Past experience tends to be determined by one of either two methods. Both of these methods involve the Plan classifying vendors by category, i.e. small, or large business, small women owned business, SBA certified small disadvantaged owned

business and small HUBZone business, and now veteran and disabled veteran owned small business. The two methods are:

(a) front end or zero based budget approach which involves looking at budgets, discussing with various department heads, etc., and determining what is anticipated to be purchased in the future period, and then breaking it down into what can reasonably be expected to be awarded to each of the four categories.

(b) the back end or accounts payable approach, which is, to ignore actual contracts and purchase orders issued and look at the corporate-wide accounts payable files for the previous period. The actual payments to vendors can then be analyzed by small business category, as well as cost or program objective. It is then a simple enough process to either directly calculate an amount applicable to FEP by cost code, or to prorate an amount applicable to FEP in each category based on FEP as a proportion of the Plans total business. This second method is the more common as it tends to bring in a fair share of indirect costs. Once a firm picture of the previous period's business is defined, a reasonable estimate of the future period can be made.

This consolidated 2006 (fiscal year) FEP Subcontracting Plan is based on the following:

1. Actual SADBUS data for the period September 1, 2002 through March 30, 2005.

2. Total overall purchasing estimates submitted by the various BCBS Plans for Calendar year 2004.

3. Data contained in BCBS Plan SADBUS Subcontracting Plans for Fiscal Year 2006.

J. Indirect costs have ___X___ have not _____ been included in the dollar and percentage subcontracting goals stated above. (Check one)

K. If indirect costs have been included, explain the method used to determine the proportionate share of such costs to be allocated as subcontracts to targeted firm(s).

Indirect costs are included in most Plan estimates as a result of the method of calculation of the estimates as described in the preceding paragraph dealing with how the basic estimates are calculated.

3. Program Administrator

Name, title, position within the corporate structure, and duties and responsibilities of the employee who will administer the Carrier's subcontracting program.

Name:	Dwight Wolfe
Title	Program Manager, FEP Procurement
Address:	Blue Cross and Blue Shield Association 1310 G Street, N.W. Washington, D.C. 20005
Telephone:	(202) 942-1283

Duties: Has general overall responsibility for the Carrier's subcontracting program, i.e., developing, preparing, and executing individual subcontracting plans and monitoring performance relative to the requirements of this particular plan. These duties include, but are not limited to the following activities:

A. Developing and promoting company-wide policy initiatives that demonstrate the company's support for awarding contracts and subcontracts to targeted firm(s); and assuring that targeted firm(s) are included on the source lists for solicitations for products and services they are capable of providing;

B. Developing and maintaining bidder's lists of targeted firm(s) from all possible sources;

C. Ensuring periodic rotation of potential subcontractors on bidders lists;

D. Ensuring that procurement "packages" are designed to permit the maximum possible participation of targeted firm(s);

E. Making arrangements for utilization of various sources for the identification of targeted firm(s) such as the SBA's Procurement IAE Central Contractor Registration (CCR), the National Minority Purchasing Council Vendor Information Service, the Office of Minority Business Data Center in the Department of Commerce, and the facilities of local small business and minority associations, and contact with Federal agencies' Small and Disadvantaged Business Utilization Specialists (SADBUS);

F. Overseeing the establishment and maintenance of contract and subcontract award records;

G. Attending or arranging for the attendance of company counselors at Business Opportunity Workshops, Minority Business Enterprise Seminars, Trade Fairs, Procurement Conferences, etc.;

H. Ensuring targeted firm(s) are made aware of subcontracting opportunities and how to prepare responsive bids to the company;

I. Conducting or arranging for the conduct of training for purchasing personnel regarding the intent and impact of Section 8(d) of the Small Business Act on purchasing procedures;

J. Monitoring the company's performance and making any adjustments necessary to achieve the subcontract plan goals;

K. Preparing, and submitting timely, required subcontract reports;

L. Coordinating the company's activities during the conduct of compliance reviews by Federal agencies;

M. Providing technical assistance; e.g., engineering, quality control, and managerial assistance to targeted firm(s);

N. Other Duties:

NONE

4. Equitable Opportunity

Describe efforts the Carrier will make to ensure that targeted firm(s) will have an equitable opportunity to compete for subcontracts. These efforts

include, but are not limited to, the following activities:

A. Outreach efforts to obtain sources:

1. Contacting minority and small business trade associations;

2. Contacting business development organizations;

3. Attending small and minority business procurement conferences and trade fairs;

4. Requesting sources from the Small Business Administration's IAE Central Contractor Registration CCR); and

5. Developing a BCBS Plan wide register of targeted firms.

B. Internal efforts to guide and encourage purchasing personnel:

1. Presenting workshops, seminars and training programs;

2. Establishing, maintaining and using small, small disadvantaged, and women-owned small business source lists, guides and other data for soliciting subcontracts; and

3. Monitoring activities to evaluate compliance with the subcontracting plan.

C. Additional efforts:

All of the above listed Outreach and Internal efforts are utilized by one BCBS Plan or another to endure that targeted firms will have an equitable opportunity to compete for subcontracts.

In addition, several Plans, including the FEPDO utilizes the National Minority Business Directory and U.S. Encyclopedia of Association to identify potential vendors.

5. Flow-Down clause

The Carrier agrees to include the provisions under FAR 52.219-8, "Utilization of Small, Small Disadvantaged, and Women-Owned Small Business Concerns," in all subcontracts that offer further subcontracting opportunities and exceed the threshold for small purchases of $100,000. All subcontractors, except small business concerns, that receive subcontracts in excess of $500,000 ($1,000,000 for construction) must adopt and comply

with a plan similar to the plan required by FAR 52.219-9, "Small, Small Disadvantaged, and Women-Owned Small Business Subcontracting Plan" (FAR 19.704(a)(4)).

6. Reporting and Cooperation

The Carrier gives assurance of (1) cooperation in any studies or surveys that may be required; (2) submission of periodic reports which show compliance with the subcontracting plan; (3) submission of Standard Form (SF) 294, "Subcontracting Report for Individual Contracts," and

SF-295, "Summary Subcontract Report," in accordance with the instructions on the forms; and (4) ensuring that large business subcontractors with subcontracting plans agree to submit Standard Forms 294 and 295.

Reporting Period	Report Due	Due Date
Oct 1 - March 31	SF-294	04/30
Apr 1 - Sept 30	SF-294	10/30
Oct 1 - Sept 30	SF-295	10/30*
Oct 1 – Sept 30	SMALL DISADVANTAGED BUSINESS (SDB) PARTICIPATION REPORT (SDB Dollar Listing by 3-digit NAICS Code) (Optional Form 312)**	10/30

* The Carrier will be required to submit the SF-295 annually as shown in this chart.

** This report may be on any form (computer generated acceptable) desired by the Contractor, or Optional Form 312 title, SMALL DISADVANTAGED BUSINESS (SDB) PARTICIPATION REPORT may be utilized. This report is a listing of dollars spent with SBA certified Small Disadvantaged Business firms categorized into 3 digit NAICS code categories.

ADDRESSES

(a) SF-294 (includes local plan submissions) to be submitted by FEP to the FEHBP Program contracting officer; and

(b) SF-295 (includes local plan submissions) to be submitted by FEP to the FEHBP Program contracting officer. Copies should also be sent to the Insurance Policy and Information Division, Office of Insurance Programs, OPM, and to the cognizant SBA Commercial Market Representative.

7. Special

The following is a recitation of the types of records the Carrier will maintain to demonstrate the procedures adopted to comply with the requirements and goals in the subcontracting plan. The records will include, but not be limited, to the following:

A. If the Carrier is not using CCR as its source for targeted firm(s) list the names of guides and other data identifying such vendors;

B. Organizations contacted in an attempt to locate targeted firm(s);

C. On a contract-by-contract basis, records on each subcontract solicitation resulting in an award of more than $100,000 indicating (1) whether targeted firm(s) were solicited, and if not, why not; and (3) if applicable, the reason that the award was not made to a targeted firm;

D. Records to support other outreach efforts, e.g., contacts with minority and small business trade associations, attendance at small and minority business procurement conferences and trade fairs;

E. Records to support internal guidance and encouragement provided to buyers through (1) workshops, seminars, training programs, incentive awards; and (2) monitoring of activities to evaluate compliance; and

F. On a contract-by-contract basis, records to support subcontract award data including the name, address, and business size of each subcontractor. (This item is not required on a contract-by-contract basis for company or division-wide commercial plans.)

G. Additional Records:

NONE

This subcontracting plan was submitted by:

Signature:	Rod Collins
Typed Name:	Rod Collins
Title:	Chief Operating Executive, FEP
Date Prepared:	June 30, 2005
Phone No.:	(202) 942-1220